COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX COUNTY

SUPREME JUDICIAL COURT
NO.

APPEALS COURT
NO. 2016-P-1740

COMMONWEALTH

V.

JULIE ELDRED

APPLICATION FOR DIRECT APPELLATE REVIEW

Now comes Julie Eldred and moves pursuant to Mass. R.A.P. 11 that the Court grant direct appellate review in the above-captioned case.

The grounds for this motion are set forth in the accompanying memorandum.

JULIE ELDRED

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Dated: January 17, 2017.

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX COUNTY

SUPREME JUDICIAL COURT
NO.

APPEALS COURT
NO. 2016-P-1740

COMMONWEALTH

V.

JULIE ELDRED

MEMORANDUM IN SUPPORT OF APPLICATION FOR DIRECT APPELLATE REVIEW

Julie Eldred (the probationer) seeks direct appellate review of the following question of law which has been reported to the Appeals Court pursuant to Mass. R. Crim. P. 34, as amended, 442 Mass. 1501 (2004):

> May the probationer permissibly be required to "remain drug free" as a condition of her probation, and may she permissibly be punished for violating that condition, where the probationer suffers from substance use disorder, and where her continued use of substances despite negative consequences is a symptom of that disorder.

(Add. 5)[1/]

[1/]The addendum to this application is cited by page number as "(Add.)," and is reproduced, post.

STATEMENT OF PRIOR PROCEEDINGS

On August 22, 2016, in the Concord District Court, Julie Eldred admitted to sufficient facts to find her guilty of larceny over $250, in violation of G.L. c.266, §30(1) (Add. 1, 3). The case was continued without a finding for one year (Add. 2). The Court (Brendemuehl, J.) set conditions of probation, including that Ms. Eldred "remain drug free" and "submit to random testing as required" (Add. 7).

On September 2, 2016, Ms. Eldred's probation officer filed a notice of probation violation and moved to detain Ms. Eldred after she tested positive for Fentanyl (Add. 3, 8-9). Ms. Eldred argued against detention, noting that she had recently met with an addiction specialist and had been prescribed Suboxone (Add. 9).[2/] Ms. Eldred further noted that she had recently begun treatment at the Addiction Recovery Program at Emerson Hospital, an intensive outpatient treatment program (Add. 9). The Court (Brendemuehl, J.) ordered that Ms. Eldred be held without bail until defense counsel could arrange a placement for her in a

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[2/]Suboxone and other opioid agonists "are evidence-based treatments for opioid use disorder [that] help patients achieve disease remission" (Add. 23 [Wakeman Aff. ¶53). Ms. Eldred tested positive for Suboxone as well as Fentanyl (Add. 8).

residential program (Add. 9). On September 12, 2016, the Court released Ms. Eldred to the Sheehan House in Tewksbury (Add. 9-10).

On November 22, 2016, the Court (Singh, J.) held a violation of probation hearing (Add. 3). Also on that date, Ms. Eldred filed and argued an opposition to the probation violation and a motion to remove the condition of probation ordering her to "remain drug free" (Add. 3). Ms. Eldred contended that it was unconstitutional to find her in violation for having a medical condition -- substance use disorder -- that was not in remission. In support, Ms. Eldred submitted an affidavit by Sarah Wakeman, M.D., explaining the science of addiction (Add. 17-25 [Wakeman Aff. ¶¶8-69]),[3/] and a comprehensive psychosocial history and psychiatric evaluation by Martha Kane, Ph.D., diagnosing Ms. Eldred with severe substance use disorder (Add. 25-36).[4/]

On December 7, 2016, having taken the matter under

[3/]Dr. Wakeman is the Medical Director of Massachusetts General Hospital's Substance Use Disorder Initiative and a member of Governor Baker's Opioid Addiction Working Group (Add. 20 [Wakeman Aff. ¶¶1-6]).

[4/]Dr. Kane is Clinical Director of Massachusetts General Hospital's Center for Addiction Medicine, Substance Use Disorders Initiative, and Department of Ambulatory Psychiatry (Add. 36).

advisement and invited a motion to report questions pursuant to Mass. R. Crim. P. 34, Judge Singh found Ms. Eldred in violation of probation, continued her probation, and added a condition that she "continue in-patient treatment" at the Sheehan House (Add. 4). Also on that date, Judge Singh denied Ms. Eldred's opposition to probation violation and motion to remove the probationary condition requiring her to be drug free, and allowed her motion to report a question of law pursuant to Rule 34 (Add. 4-5).

The case was entered in the Appeals Court on December 28, 2016.[5/]

STATEMENT OF FACTS RELEVANT TO THE CASE

Julie Eldred, now twenty-nine years old, was adopted as a newborn and raised in Acton by her mother and father, a retired medical social worker and retired researcher, respectively (Add. 27). According to information from the adoption agency, Ms. Eldred's birth mother suffered from substance use disorder (Add. 28).[6/] When she was seven years old, Ms. Eldred was

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[5/]Ms. Eldred has appealed Judge Singh's finding that she violated probation by not remaining drug free. That case has not yet been entered in the Appeals Court.

[6/]Genetics, certain mental illnesses, and severe stress

(FOOTNOTE CONTINUED ON NEXT PAGE)

diagnosed with attention deficit hyperactivity disorder (ADHD) due to "significant difficulty with heightened arousal, restlessness, high activity levels, and general issues with frustration tolerance" (Add. 28). These symptoms persisted throughout her childhood and teenage years "despite trials on a variety of medications, singly and in combination" (Add. 28). At age fourteen, Ms. Eldred "discovered that substance use helped reduce her negative sense of self" and helped her feel "a sense of internal calm and increased social stability" (Add. 28). Ms. Eldred used a variety of substances, feeling that they "fit[] her like a hand in a glove" (Add. 29). By her teens, Ms. Eldred had developed a substance use disorder (Add. 15 [Affidavit of Julie Eldred, ¶3]), which, by her early twenties, was "severe" (Add. 29).

Ms. Eldred's risk of developing a substance use disorder was elevated by her early drug use, ADHD and its associated emotional and developmental delays, episodic depression and anxiety, and the likelihood that her biological mother suffered from addiction (Add. 28). In 2013, Ms. Eldred began the process of

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[6/] (FOOTNOTE CONTINUED FROM PREVIOUS PAGE) are risk factors for developing a substance use disorder (Add. 19 [Wakeman Aff. at ¶¶ 24-27]).

recovery and has since "exhibit[ed] a fairly typical recovery process" involving recurring periods of remission and relapse (Add. 34).

Ms. Eldred relapsed in November 2015, after having been in remission for nearly a year (Add. 30). During this relapse, Ms. Eldred stole jewelry from the home of a client for whom she worked as a pet-walker (Add. 7). When confronted by police, Ms. Eldred confessed and said she sold the jewelry at a pawn shop for cash to support her heroin addiction (Add. 7). As a result, she was charged with larceny (Add. 7).

Ms. Eldred's addiction was active on August 22, 2016, when she admitted to sufficient facts in this case and was ordered to remain drug free (Add. 15 [Eldred Aff. ¶6]). Although she wanted to stop using drugs and knew that she faced the possibility of incarceration for continued use, she could not stop her compulsion to use. Id. Ms. Eldred has previously been on probation and been incarcerated after submitting to drug testing -- that is, urinating in front of a probation officer (Add. 10). Ms. Eldred experiences drug testing as dehumanizing, violating, and shaming (Add. 19 [Eldred Aff. ¶10]). She also feels traumatized by being placed in handcuffs, locked in a cell,

and sent to MCI-Framingham for being substance-addicted (Add. 16 [Eldred Aff. ¶15]). "Knowing that a relapse leads to a probation violation makes it harder for [Ms. Eldred] to talk about [her] struggles for fear of being locked up" (Add. 16 [Eldred Aff. ¶13]).

STATEMENT OF ISSUE OF LAW RAISED BY THE CASE

May the probationer permissibly be required to "remain drug free" as a condition of her probation, and may she permissibly be punished for violating that condition, where the probationer suffers from substance use disorder, and where her continued use of substances despite negative consequences is a symptom of that disorder.

ARGUMENT

Ordering Ms. Eldred to "remain drug free" as a condition of probation, and incarcerating her for violating that condition, violates the prohibition against cruel and unusual punishment, as well as due process and equal protection.

A. Substance use disorder is a chronic, relapsing brain disease.

Substance use disorder (i.e. "addiction") is a complex, all-consuming, developmental, and chronic brain disease expressed as the compulsive use of a substance despite negative consequences (Add. 18 [Wakeman Aff. ¶¶8-9]), citing Am. Psychiatric Ass'n,

Diagnostic and Statistical Manual of Mental Disorders 483 (5th ed. 2013) (DSM-V). DSM-5 defines the condition as a "cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems . . . [due to] an underlying change in the brain circuits." Id. at 483. "Research has shown that long-term drug []use results in changes in the brain that persist long after a person stops using drugs. These drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse [to use] -- the defining characteristic of addiction." National Institutes of Health, Principles of Drug Addiction Treatment 7 (2012).

Recent brain research has improved the understanding of addiction as a neurological disorder -- not a moral failing:

> For much of the past century, scientists studying drug [addiction] labored in the shadows of powerful myths and misconceptions about the nature of addiction. When scientists began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to drug [addiction], treating it as a moral failing rather than a health problem, which led to an emphasis on punishment rather than prevention and treatment. Today, thanks

> to science, our views and our responses to addiction and other substance use disorders have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of compulsive drug use, enabling us to respond effectively to the problem.

National Institute on Drug Abuse, Drugs, Brains, and Behavior: The Science of Addiction 1 (2014 ed.).

As with other chronic diseases, recovery from addiction is a long-term process in which periods of remission may be interrupted by periods of active illness (Add. 22 [Wakeman Aff. ¶43]). "The chronic nature of addiction means that relapsing to drug use is not only possible but also likely. Relapse rates are similar to those for other well-characterized chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components." National Institute on Drug Abuse, The Science of Drug Abuse and Addiction: The Basics.

Punishing a person with substance use disorder for relapsing does not address the neurobiological etiology of the medical condition. "[C]enturies of efforts to reduce addiction and its related costs by punishing addictive behaviors [have] failed to produce adequate results." Nora D. Volkow, George F. Koob, & A. Thomas

McLellan, Neurobiologic Advances from the Brain Disease Model of Addiction, 374 New England J. Med. 363, 363 (2016). Evidence-based practices for treating addiction are driven by the individual's needs and preferences, and are rooted in hope and respect for the individual (Add. 23 [Wakeman Aff. ¶57]). When a person is addicted, ordering, shaming, or threatening the person to stop using drugs is counterproductive and damaging, as it usually triggers shame, anger, opposition, or avoidance. Id. at ¶56.

B. Punishing Ms. Eldred for not being cured of substance use disorder violates the prohibition against cruel or unusual punishment.

Ordering that Ms. Eldred, who has been diagnosed with substance use disorder, to be drug free or face criminal consequences is the equivalent of ordering that she be cured, or at least in remission, of her disorder through the duration of her probation. In view of the current scientific research establishing that addiction is a chronic, relapsing brain disease, ordering that Ms. Eldred be drug free (i.e., asymptomatic) and imposing criminal sanctions for not being drug free violates the constitutional prohibition against cruel or unusual punishment.

In Robinson v. California, 370 U.S. 660 (1962),

the Supreme Court invalidated, on Eighth Amendment grounds, a California statute that made it a crime "for a person to 'be addicted to the use of narcotics.'" Id. at 660. A jury had convicted Robinson based on evidence of needle marks on his arms and his admission that he had used narcotics in the past. The Court held that, insofar as it made it a crime to be "addicted to the use of narcotics," even if the person had not touched a drug, the statute punished a status offense (i.e. the "'chronic condition' . . . of being 'addicted to the use of narcotics'") and thus unconstitutionally exposed an individual bearing this status to "arrest at any time before he reforms." Id. at 662, 665. "It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. . . . [I]n light of contemporary knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments." Id. at 666 (emphasis added). "Even one day in prison would be cruel and unusual punishment for the 'crime' of a common cold." Id. at 667. "If addicts can be

punished for their addiction, then the insane can also be punished for their insanity. Each has a disease and each must be treated as a sick person." Id. at 674 (Douglas, J., concurring).

It is undisputed that Ms. Eldred suffers from substance use disorder, "a medical illness[] . . . involv[ing] impaired control over substance use that results in disruption of specific brain circuits." U.S. Department of Health & Human Services, Facing Addiction in America, The Surgeon General's Report on Alcohol, Drugs, and Health, 7-3 (2016) (the Surgeon General's Report). Following Robinson, fifty years of research evidencing that addiction is a chronic, relapsing brain disease compels the conclusion that to criminally sanction Ms. Eldred for drug use, given her medical condition, is the equivalent of criminalizing her status of having a substance use disorder. Even assuming that it is permissible to require that Ms. Eldred remain in appropriate addiction treatment as a condition of probation, ordering that she be drug free and submit to drug testing to prove that she is in remission, and punishing her for testing positive, violates her right to be free of cruel or unusual punishment. Whether or not the Supreme Court would so

hold under the Eighth Amendment, cf. Powell v. Texas, 392 U.S. 514 (1969), "the rights guaranteed under art. 26 [of the Declaration of Rights] may be broader." Commonwealth v. Okoro, 471 Mass. 51, 61 (2015), citing Michaud v. Sheriff of Essex County, 390 Mass. 523, 533-534 (1983) (art. 26 "draw[s] its meaning from the evolving standards of decency that mark the progress of a maturing society").

C. Requiring Ms. Eldred to be cured or in remission from her substance use disorder as a condition of probation violates her right to due process.

"A defendant can be found in violation of a probationary condition only where the violation was wilful," Commonwealth v. Henry, 475 Mass. 117, 121 (2016), and "may not be found . . . in violation . . . where those conditions, despite diligent effort, cannot be met." Commonwealth v. Al Saud, 459 Mass. 221, 231 (2011), citing Commonwealth v. Poirier, 458 Mass. 1014 (2010) (finding of probation violation based on failure to comply with requirement to wear global positioning system monitor was unwarranted when department did not provide probationer with means to comply).

A "probationer is entitled to an opportunity to show not only that he did not violate the conditions

[of probation], but also that there was a justifiable excuse for any violation or that revocation is not the appropriate disposition." Commonwealth v. Canadyan, 458 Mass. 574, 578 (2010) (citation omitted). In Canadyan, the Court held that to find the defendant, who was homeless, in violation of probation for not complying with an electronic monitoring condition, where he had no access to the necessary technology, was unwarranted and akin to punishing the defendant for being homeless. Id. at 579.

Similarly, court-ordering Ms. Eldred to be drug free as a condition of probation and criminally sanctioning her for non-compliance is akin to punishing her for not being cured of or in remission from her chronic medical condition of substance use disorder. Extensive neuroscience research has established that addiction is a medical condition involving structural alterations to the brain even after the person ceases using substances (Add. 20 [Wakeman Aff. ¶¶29-31]). "Repeated substance use induces a series of neuroadaptations in various neuronal circuits in the brain that are involved in motivation, memory, behavior control and disinhibition." Id. at ¶32. "The person suffering from a substance use disorder compulsively

seeks one or more substances and is unable to exert control over the impulse to use despite negative consequences -- such as criminal [sanctions] -- including incarceration" (Add. 19 [Wakeman Aff. ¶14). The damage to the brain impacting motivation and self-control means that people suffering from addiction remain at risk for relapse even after long periods of abstinence (Add. 20 [Wakeman Aff. ¶¶33-34).

In view of current scientific understanding of substance use disorder as a brain disease, Ms. Eldred's inability to remain drug free cannot be viewed as willful noncompliance of a court order. Absent such willfulness, a finding that she violated probation offends due process, as guaranteed by the Fourteenth Amendment to the United States Constitution and art. 12 of the Declaration of Rights. See Canadyan, 458 Mass. at 579, citing Bearden v. Georgia, 461 U.S. 660, 669 n.10 (1983) ("basic fairness forbids the revocation of probation when the probationer is without fault in his failure to [comply]").

D. Requiring Ms. Eldred to be cured of or in remission from her substance use disorder as a condition of probation violates her right to equal protection.

"Under both the Federal and State Constitutions,

. . . State action violates equal protection rights if it subjects persons to classification resulting in different treatment, . . . and if, as here, there is no rational relationship between the line drawn and a legitimate State interest." Commonwealth v. Arment, 412 Mass. 55, 62-63 (1992). Although it may be rational to require that Ms. Eldred engage in addiction treatment, ordering that she be cured of or in remission from her addiction (i.e., drug free as evidenced by negative drug screens) is irrational in view of her substance use disorder -- a chronic, relapsing brain disease. By contrast, even though symptoms of other mental disorders, such as mania or auditory hallucinations, may contribute to criminal conduct, no Court would forbid an individual suffering from bipolar disorder or schizophrenia from experiencing mania or auditory hallucinations as a condition of probation. The condition ordering Ms. Eldred to be drug free thus irrationally burdens the class of chronically ill individuals who suffer from substance use disorder, in violation of her state and federal rights to equal protection of the laws.

STATEMENT OF REASONS WHY
DIRECT APPELLATE REVIEW IS APPROPRIATE

In 2016, the first-ever Surgeon General's Report on Alcohol, Drugs, and Health issued, noting that "[i]t is time to change how we as a society address alcohol and drug misuse and substance use disorders."

> Scientific breakthroughs have revolutionized the understanding of substance use disorders. For example, severe substance use disorders, commonly called addictions, were once viewed largely as a moral failing or character flaw, but are now understood to be chronic illnesses characterized by clinically significant impairments in health, social function, and voluntary control over substance use. Although the mechanisms may be different, addiction has many features in common with disorders such as diabetes, asthma, and hypertension. All of these disorders are chronic, subject to relapse, and influenced by genetic, developmental, behavioral, social, and environmental factors. In all of these disorders, affected individuals may have difficulty complying with the prescribed treatment.

The Surgeon General's Report at 2-1.

The practice of court-ordering defendants to be drug free and imposing criminal sanctions for non-compliance stems from an era pre-dating our contemporary scientific understanding of addiction as a chronic, relapsing, brain disorder. In view of the current research, the reported question is "of such public interest that justice requires a final determination by [this] Court." Mass. R. A.P. 11(a), (3).

CONCLUSION

For the above-stated reasons, the Court should grant the application for direct appellate review.

Respectfully submitted,

JULIE ELDRED

By her counsel,

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Dated: January 17, 2017.

CRIMINAL DOCKET	DOCKET NUMBER	NO. OF COUNTS	Trial Court of Massachusetts District Court Department
	1647CR000901	1	

DEFENDANT NAME AND ADDRESS	DOB	GENDER	COURT NAME & ADDRESS
Julie A Eldred 8 Fairway Road Acton, MA 01720	11/30/1987	Female	Concord District Court 305 Walden Street Concord, MA 01742
	DATE COMPLAINT ISSUED 06/13/2016		
	PRECOMPLAINT ARREST DATE		INTERPRETER REQUIRED

FIRST FIVE OFFENSE COUNTS

COUNT	CODE	OFFENSE DESCRIPTION	OFFENSE DATE
1	266/30/A	LARCENY OVER $250 c266 §30(1)	03/28/2016

DEFENSE ATTORNEY	OFFENSE CITY/TOWN	POLICE DEPARTMENT
McGuinness	Maynard	MAYNARD PD

DATE & JUDGE	DOCKET ENTRY	DATE & JUDGE	FEES IMPOSED
7.18.16 Swan	☒ Attorney appointed (SJC R. 3:10) ☐ Atty denied & Deft. Advised per 211 D §2A ☐ Waiver of Counsel found after colloquy	7.18.16 Swan	Counsel Fee (211D § 2A¶2) $ 150 ☐ WAIVED Counsel Contribution (211D § 2) $ ☐ WAIVED
	Terms of release set: no drugs ☒ PR ☐ Bail SJA(V) ☒ See Docket for special condition RLS Contact tx sign release ☐ Held (276 §58A)		Default Warrant Fee (276 § 30¶1) $ ☐ WAIVED Default Warrant Arrest Fee (276 § 30 ¶2) $ ☐ WAIVED
7.18.16 Swan	Arraigned and advised: ☒ Potential of bail revocation (276 §58B) ☒ Right to bail to review (276 §58) ☐ Right to drug exam (111E § 10) ☐ Inquiry made by Court under 276 § 56A	8-22-16 Brendemuhl	Probation Supervision Fee (276 § 87A) $ 65 in C/S waived ☐ WAIVED Bail Order Forfeited while paym Forfeit
	Abuse Allegation: ☐ C276 § 56A form filed by Commonwealth ☐ Allegation of abuse under C276 § 56A found ☐ No allegation of abuse under C276 § 56A found		Advised of right to jury trial: ☐ Waiver of jury found after colloquy ☐ Does not waive Advised of trial rights as pro se (Dist. Ct. Supp.R.4) Advised of right of appeal to Appeals Ct. (M.R. Crim P.R. 28)

SCHEDULING HISTORY

NO.	SCHEDULED DATE	EVENT	RESULT	JUDGE	TAPE START/ STOP
1	07/18/2016	Arraignment	☒ Held ☐ Not Held but Event Resolved ☐ Cont'd	Swan	
2	8-22-16	PT	☐ Held ☒ Not Held but Event Resolved ☐ Cont'd	Brendemuhl	
3	11-28-16	RH	☐ Held ☒ Not Held but Event Resolved ☐ Cont'd	Sarason	
4			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
5			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
6			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
7			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
8			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
9			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		
10			☐ Held ☐ Not Held but Event Resolved ☐ Cont'd		

APPROVED ABBREVIATIONS

ARR = Arraignment PTH = Pretrial hearing DCE = Discovery compliance & jury selection BTR = Bench trial JTR = Jury trial PCH = Probable cause hearing MOT = Motion hearing SRE = Status review SRP = Status review of payments FAT = First appearance in jury session SEN = Sentencing CWF = Continuance-without-finding scheduled to terminate PRO = Probation scheduled to terminate DFTA = Defendant failed to appear & was defaulted WAR = Warrant issued WARD = Default warrant issued WR = Warrant or default warrant recalled PVH = probation revocation hearing

A TRUE COPY ATTEST:	CLERK-MAGISTRATE / ASST CLERK	TOTAL NO. OF PAGES	ON (DATE)
	X		

TRUE COPY OF THE RECORD
ATTEST: [signature]
CONCORD DIV.
CLERK/MAGISTRATE

Date/Time Printed: 06-13-2016 14:02:22

1234567890

Revised: 01/16

CRIMINAL DOCKET - OFFENSES

DEFENDANT NAME: Julie A Eldred

DOCKET NUMBER: 1647CR000901

COUNT / OFFENSE: 1 LARCENY OVER $250 c266 §30(1)

DISPOSITION DATE AND JUDGE: 8-22-16 Brendemuhl

DISPOSITION METHOD
- ☐ Guilty Plea or ☐ Admission to Sufficient Facts accepted after colloquy and alien warning pursuant to C278§29D and MRCrP12
- ☐ Bench Trial
- ☐ Jury Trial
- ☐ Dismissed upon:
  - ☐ Request of Commonwealth ☐ Request of Victim
  - ☐ Request of Defendant ☐ Failure to prosecute
  - ☐ Other:
- ☐ Filed with Defendant's consent
- ☐ Nolle Prosequi
- ☐ Decriminalized (277 §70 C)

FINE/ASSESSMENT	SURFINE	COSTS	OUI §24D FEE	OUI VICTIMS ASMT
HEAD INJURY ASMT	**RESTITUTION**	**V/W ASSESSMENT**	**BATTERER'S FEE**	**OTHER**
		90		

SENTENCE OR OTHER DISPOSITION
- ☐ Sufficient facts found but continued without a finding until: 8-2-17
- ☐ Defendant placed on probation until:
  - ☐ Risk/Need or OUI ☐ Administrative Supervision
- ☐ Defendant placed on pretrial probation (276 §87) until:
- ☐ To be dismissed if court costs / restitution paid by:

RIS
AA/NA 3x wk
E/C outpt substance
Rest TBD
Sign releases
S/A victim

See 12-8-16 & Supp

FINDING
- ☐ Guilty ☐ Not Guilty
- ☐ Responsible ☐ Not Responsible
- ☐ Probable Cause ☐ No Probable Cause

FINAL DISPOSITION — JUDGE — DATE
- ☐ Dismissed on recommendation of Probation Dept.
- ☐ Probation terminated: defendant discharged
- ☐ Sentence or disposition revoked (see cont'd page)

COUNT / OFFENSE

DISPOSITION DATE AND JUDGE

DISPOSITION METHOD
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HEAD INJURY ASMT	**RESTITUTION**	**V/W ASSESSMENT**	**BATTERER'S FEE**	**OTHER**

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FINDING
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- ☐ Responsible ☐ Not Responsible
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COUNT / OFFENSE

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  - Other:
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- ☐ Nolle Prosequi
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FINE/ASSESSMENT	SURFINE	COSTS	OUI §24D FEE	OUI VICTIMS ASMT
HEAD INJURY ASMT	**RESTITUTION**	**V/W ASSESSMENT**	**BATTERER'S FEE**	**OTHER**

SENTENCE OR OTHER DISPOSITION
- ☐ Sufficient facts found but continued without a finding until:
- ☐ Defendant placed on probation until:
  - ☐ Risk/Need or OUI ☐ Administrative Supervision
- ☐ Defendant placed on pretrial probation (276 §87) until:
- ☐ To be dismissed if court costs / restitution paid by:

FINDING
- ☐ Guilty ☐ Not Guilty
- ☐ Responsible ☐ Not Responsible
- ☐ Probable Cause ☐ No Probable Cause

FINAL DISPOSITION — JUDGE — DATE
- ☐ Dismissed on recommendation of Probation Dept.
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- ☐ Sentence or disposition revoked (see cont'd page)

A TRUE COPY OF THE RECORD
ATTEST: [signature] DATE
CONCORD DIV.
CLERK/MAGISTRATE

CRIMINAL DOCKET DOCKET ENTRIES	DEFENDANT NAME Julie A Eldred	DOCKET NUMBER 1647CR000901

DATE	DOCKET ENTRIES
8-22-16	plea tendered 9:35-9:45 J Brendemuehl
9-2-16	Notice PTH, Notice P.V.R. Δ detent hrg filed Prob detent hrg + fndg. filed & VOP Request Detent + allowed. Δ held w/o bond Prob detent to issue 9-19-16 final agmt attys Neuman Polk $150 CF J Brendemuehl (12:29:29 12:36:00)
9-8-16	Request Not filed + allowed case adv 9-12-16 hrg to issue MCJ from for that date
9-12-16	(M) fndgs filed + allowed Δ released from custody case 11-9-16 for adj Δ released on cond and enter Sheehan House J Brendemuehl
10-6-16	(M) advance and continue filed and allowed, case c. 11-22-16 for fin. pvrr. Brendemuehl J
11-22-16	VOP hearing held, matter U/A. Δ's Opposition to (M) VOP (M) filed. Case c. 11-28-16 RH J. Singh (10:06-10:33)
11-28-16	after hearing, no rest. has been imposed. J. Larason (10:35)
~~11-28-16~~	~~VOP Admitted. Probation to end be revoked following conditions: Δ to continue in-patient treatment at Sheehan House~~

APPROVED ABBREVIATIONS
ARR = Arraignment PTH = Pretrial hearing DCE = Discovery compliance & jury selection BTR = Bench trial JTR = Jury trial PCH = Probable cause hearing MOT = Motion hearing SRS = Status review/
SRP = Status review of payments FAT = First appearance in jury session SEN = Sentencing CWF = Continuance-without-finding scheduled to terminate PRO = Probation scheduled to terminate
DFTA = Defendant failed to appear & was defaulted WAR = Warrant issued WARD = Default warrant issued WR = Warrant or default warrant recalled PVH = probation revocation hearing

A TRUE COPY OF THE RECORD
ATTEST:
CONCORD DIV.
CLERK/MAGISTRATE

Date/Time Printed 08-13-2018 14:02:22

Revised: 01/18

DOCKET CONTINUATION	NAME OF CASE	DOCKET NUMBER
	Julie Eldred	1647CR901

NO.	DATE	DOCKET ENTRIES
	12-08-16	VOP found. Probation stands, new condition added: D to continue in-patient treatment at Shelhan House. D's Opposition to P.Viol denied, (H) report question of law allowed. Parties notified per clerk. Prob Viol. Finding & Disp filed. J. Singh.
	12/19/16	Appellate Court Entry Statement filed. (M) rept: filed w Appeals ct Notice of Assembly Record filed Notice sent to all parties

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss. CONCORD DISTRICT COURT
1647CR000901

COMMONWEALTH

V.

JULIE ELDRED

Allowed. Court adopts 9-11 1-17 herein 28 facts relevant to reported question.
Sinnott, J.
12-7-16

MOTION TO REPORT QUESTION OF LAW AND PROPOSED FINDINGS OF FACT

Now comes the probationer, Julie Eldred, pursuant to Mass. R. Crim. P. 34, as amended, 442 Mass. 1501 (2004), and requests that the following question be reported for decision by the Appeals Court:

> **May the probationer permissibly be required to "remain drug free" as a condition of her probation, and may she permissibly be punished for violating that condition, where the probationer suffers from substance use disorder, and where her continued use of substances despite negative consequences is a symptom of that disorder.**

In support, the probationer states that this question is raised by the facts pertaining to the pending violation of probation allegation and is "so important or doubtful as to require the decision of the Appeals Court." Commonwealth v. Porges, 460 Mass. 525, 527 (2011), quoting

Mass. R. Crim. P. 34. The probationer further submits that the pertinent facts are set forth in the affidavits and other papers accompanying her Opposition to Probation Violation and Motion to Change Probation Conditions (filed on November 21, 2016), and are not in dispute. Accordingly, the probationer suggests that the report incorporate the substance of those papers by reference and that the record accompanying the report include copies thereof. See attached Appendix.[1/]

1. The probationer, Julie Eldred, is diagnosed with substance use disorder (App. 62).[2/]

[1/]In addition to the Opposition to Probation Violation (App. 14-91), the appendix includes copies of relevant documents from the clerk's and probation department's files (App. 1-13), and copies of documents presented to the Court at the hearings held in this matter on September 2, 2016, and November 22, 2016 (App. 92-93). The signed original of Ms. Eldred's affidavit -- an unsigned copy of which appears at App. 19-20 -- was filed in Court on November 22, 2016.

[2/]Substance use disorder (SUD) is a "common, complex, consistent and predictable, all-consuming, developmental and chronic brain disease expressed as compulsive behavior through continued use of a substance despite negative con sequences" (App. 21), citing Am. Psychiatric Ass'n, Diagnostic Statistic Manual of Mental Disorders 483 (5th ed. 2013). SUD results in an alteration of brain struc-

(continued...)

2. On July 18, 2016, Ms. Eldred was charged by Concord District Court complaint number 1647CR000901 with larceny of property valued over $250, in violation of G.L. c.266, §30(1) (App. 1).

3. Ms. Eldred stole jewelry from the home of a client for whom she was working as a pet-walker (App. 8). When confronted by the police, Ms. Eldred confessed and said that she had sold the jewelry to a pawn shop in Hudson for cash to support her heroin addiction (App. 8, 18).

4. On August 22, 2016, Ms. Eldred admitted to sufficient facts (App. 2-3). The Court (Brendemuehl, J.) continued the case without a finding of guilt (CWOF) for one year and placed Ms. Eldred on probation (App. 2-3).

5. As special conditions of probation, Ms. Eldred was ordered to remain "drug free" and to "submit to random testing as required" (App. 10).

[2/](...continued)
ture and function, such that "fundamental motivational and self-control systems are damaged ... and cannot function properly" (App. 23). "Relapse and ongoing substance use is a symptom of the disorder" (App. 27).

6. She also was ordered to "continue with treatment" and attend three Alcoholics Anonymous or Narcotics Anonymous meetings per week (App. 10).

7. On August 24, 2016, Ms. Eldred "completed her intake appointment" at the Addiction Recovery Program at Emerson Hospital (App. 93).

8. Also on August 24, 2016, Ms. Eldred met with Dr. Brian O'Connor, an addiction specialist, who prescribed Suboxone (App. 16, 18, 92).[3/]

9. On August 29, 2016, Ms. Eldred began the Intensive Outpatient Program at the Addiction Recovery Program (App. 18, 93).

10. On September 2, 2016, Ms. Eldred met with her probation officer, Wanda L. Rosario, and provided her with a urine sample for purposes of drug screening (App. 11).

11. The screen came back positive for Fentanyl and Suboxone (App. 11).[4/]

[3/]Suboxone and other opioid agonists "are evidence-based treatments for opioid use disorder [that] help patients achieve disease remission" (App. 26).

[4/]The "ICUP Drug Test & Alco-Sensor Intoximeter Testing

(continued...)

12. The probation department moved to detain Ms. Eldred for violating the terms of her probation based on the positive screen for Fentanyl (App. 12-13).

13. Ms. Eldred opposed detention, noting that she had recently been prescribed and had started taking Suboxone and had begun intensive outpatient treatment (App. 16, 92-93).

14. The Court (Brendemuehl, J.) ordered that Ms. Eldred be held without bail until defense counsel could find a placement for her in a residential treatment program (App. 16).

15. Defense counsel was able to secure a bed for Ms. Eldred at the Glenice Sheehan Women's Program (the Sheehan House), where Ms. Eldred had previously been admitted for substance use disorder treatment (App. 17, 19).

16. Ms. Eldred was released to the Sheehan House on

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[1]/(...continued)
Form" indicates that Ms. Eldred's drug screen was positive for buprenorphine ("BUP") and Fentanyl ("FLY") (App. 11). Buprenorphine is the opioid agonist in Suboxone. See National Alliance of Advocates for Buprenorphine Treatment, What exactly is Buprenorphine? (available at https://www.naabt.org/faq_answers.cfm?ID=2).

September 12, 2016 (App. 3).

17. In addition to this case, Ms. Eldred has previously been placed on probation and incarcerated after testing positive for drugs (App. 19).

Respectfully submitted,

JULIE ELDRED
By her attorneys:

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Dated: December 2, 2016.

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

CONCORD DISTRICT COURT
DOCKET NO. 1647-CR-901

COMMONWEALTH

v.

JULIE ELDRED

DEFENDANT'S OPPOSITION TO PROBATION VIOLATION AND MOTION TO CHANGE CONDITIONS OF PROBATION

Now comes the defendant, Julie Eldred, pursuant to Massachusetts Rules of Criminal Procedure Rule 29 and Rule 30(a), and requests that she not be found in violation of probation and moves this Honorable Court to vacate the probation condition ordering her to be "drug free" and "submit to random testing."

As grounds, Ms. Eldred states that she suffers from a substance use disorder---a medical condition defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, p. 483, as continued use of substances "despite significant substance-related problems" due to "an underlying change in the brain circuits." Ordering Ms. Eldred not to use substances is no different than ordering a person with heart disease to go into remission. Continued drug use and relapse are symptoms of substance use disorder. Imposing criminal sanctions on a person suffering from this medical condition violates the prohibition against cruel and unusual punishment, due process, and equal protection, as guaranteed by articles 1, 10, 12 and 26 of the Declaration of Rights, and the Eighth and Fourteenth Amendments to the United States Constitution.

In support of this motion, Ms. Eldred submits the accompanying affidavits, memorandum of law, and other attachments.

Respectfully submitted,
JULIE ELDRED
By her counsel

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November 21, 2016

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

CONCORD DISTRICT COURT
DOCKET NO. 1647-CR-901

COMMONWEALTH

v.

JULIE ELDRED

AFFIDAVIT IN SUPPORT OF DEFENDANT'S OPPOSITION TO PROBATION VIOLATION AND MOTION TO CHANGE CONDITIONS OF PROBATION

I, LISA NEWMAN-POLK, do hereby depose and state as follows:

1. I represent the defendant, Julie Eldred, in a violation of probation in the above-captioned case.

2. On August 22, 2016 (represented by different counsel), Ms. Eldred admitted to sufficient facts to find her guilty of larceny over $250. The Court continued the case without a finding of guilt until August 21, 2017. As conditions of probation, Ms. Eldred was ordered to be "drug free" and to "submit to random testing as required." She also was ordered to have no contact with the named victim, to continue with treatment, and to attend three Alcoholics Anonymous or Narcotics Anonymous meetings per week.

3. On September 2, 2016, Ms. Eldred met with her probation officer, Wanda Rosario. At this time, Ms. Eldred submitted to her first probation drug test.

4. Ms. Eldred's urine test showed positive for Fentanyl.

5. Officer Rosario filed a Notice of Probation Violation, alleging a positive test screen for Fentanyl, and moved to detain Ms. Eldred.

6. I argued against detention, noting that Ms. Eldred had recently met with an addiction specialist, Dr. Brian O'Connor at Middlesex Recovery, who prescribed Suboxone, which Ms. Eldred had just started (as confirmed by the drug screen). I also noted that three days earlier Ms. Eldred had started the Addiction Recovery Program at Emerson Hospital, an intensive outpatient treatment program.

7. The Court (Brendemuehl, J.) detained Ms. Eldred instructing that she could be released from jail once defense counsel had arranged for a residential program.

8. Because Ms. Eldred had previously resided at Sheehan House in Tewksbury and therefore had a prior relationship with the program directors, I was able to secure her admittance ahead of the wait list.

9. After ten days at MCI-Framingham, Ms. Eldred was released to the Sheehan House.

10. Ms. Eldred is diagnosed with Substance Use Disorder, as well Attention Deficit Hyperactivity Disorder (ADHD), and situational depression and anxiety.

11. Based on my professional training and experience, as well as consultation with addiction specialists, I am aware that drug use and relapse are symptoms of substance use disorder, a recognized medical condition. See Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, at 483.

12. Martha Kane, Ph.D., Clinical Director for the Center for Addiction Medicine, Clinical Director of the Substance Use Disorder Initiative, and Clinical Director of Ambulatory Psychiatry at Massachusetts General Hospital conducted a psychiatric evaluation of Ms. Eldred and wrote a report, attached to this motion.

13. Sarah Wakeman, M.D., Medical Director for Substance Use Disorders at the Center for Community Health Improvement at Massachusetts General Hospital, who has written many peer-reviewed articles on substance use disorder[s] and incarceration, and is a member of Governor Baker's opioid task force, has provided an affidavit, attached to this motion, explaining the science of addiction.

14. A copy of *Neurobiological Advances from the Brain Disease Model of Addiction*, by Nora D. Volkow, George F. Koob, & A. Thomas McLellan, 374 New England J. Med. 363, 363 (2016), is also attached.

15. I have reviewed the law as well as multiple materials on addiction. I have attached a memorandum of law in support of this motion.

I hereby affirm that the foregoing facts are true and correct to the best of my knowledge and belief. Signed under the pains and penalties of perjury this date: 11/21/16.

LISA NEWMAN-POLK
BBO# 665570

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

CONCORD DISTRICT COURT
DOCKET NO. 1647-CR-901

COMMONWEALTH

v.

JULIE ELDRED

AFFIDAVIT IN SUPPORT OF DEFENDANT'S OPPOSITION TO PROBATION VIOLATION AND MOTION TO CHANGE CONDITIONS OF PROBATION

I, JULIE ELDRED, do hereby depose and state as follows:

1. I am the defendant in the above-captioned case.

2. In this case, I stole jewelry from a client while I was working as a pet-walker. I stole the jewelry because I needed money to pay for drugs due to my addiction. I ultimately confessed to the crime.

3. I have struggled with addiction since I was a teenager. In 2014 and 2015, I had a period of sobriety with the help of treatment and my parents. I relapsed in November 2015 because I slowly stopped attending to my recovery/treatment plan.

4. I am currently on probation in the Concord District Court with an order that I must be drug-free and submit to drug screens. I was incarcerated for ten days after I tested positive for Fenatynl at my first drug screen in this case.

5. When I pled in this case, I had the understanding that in order to receive a CWOF and protect my record from a felony conviction, I had to accept the term of probation that required me to be drug-free and submit to drug testing, as well as resume treatment.

6. At the time of pleading in this case, I had every sincere intention of being drug-free. At this time, however, I was still actively using and could not stop.

7. Soon after pleading to the CWOF on August 22, 2016, I attended an intake at Emerson Hospital for the Addiction Recovery Program on August 24, 2016. I started the Emerson program on August 29, 2016. I also initiated treatment with Dr. Brian O'Connor at Middlesex Recovery. A few days later, I was incarcerated on September 2, 2016 for testing positive for Fentanyl.

8. I was previously on probation over a period of two years (3/26/13 to 3/25/15); most of this time I was in the Concord Drug Court. As a condition of probation I was ordered to be drug-free and submit to drug screens. During this time I was incarcerated for relapse.

9. The Court has never civilly committed me on a Section 35.

10. When the Court drug tests me, I must urinate into a cup in front of a probation officer. This is a dehumanizing experience that makes me feel shamed and violated.

11. My addiction has been an extremely difficult and painful struggle.

12. It puts a great deal of stress on me knowing that a relapse or slip with drug use will result in my incarceration. This stress makes it hard for me to focus on my main goal, which is getting better.

13. Knowing that a relapse leads to a probation violation makes it harder for me to talk about my struggles for fear of being locked up.

14. When I have tested positive for drugs and the Court has sent me to MCI-Framingham – where I am strip-searched and housed with women who have killed people – it makes me feel like my addiction is a crime in of itself.

15. It is a traumatic experience being placed in handcuffs and knowing that I am going to jail where I have no rights because I continue to struggle with my addiction, even though I show up to court, acknowledge my struggles, I am in treatment, and have not committed new crimes against others.

16. Jail has not helped me in my recovery. It has been damaging. I credit treatment, Narcotics Anonymous, and my extremely supportive parents with my recovery progress.

17. It has been critical that I have found the right treatment for myself, as I have been to programs that did not fit my particular needs well. I researched and found the Sheehan House, which has been the only residential program that has worked well for me.

18. My addiction is a life-long condition and I know that I need to be vigilant in my recovery for the rest of my life.

I hereby affirm that the foregoing facts are true and correct to the best of my knowledge and belief. Signed under the pains and penalties of perjury this date:
11/22/16.

Julie Eldred
JULIE ELDRED

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

CONCORD DISTRICT COURT
DOCKET NO. 1647-CR-901

COMMONWEALTH

v.

JULIE ELDRED

AFFIDAVIT IN SUPPORT OF DEFENDANT'S OPPOSITION TO PROBATION VIOLATION AND MOTION TO CHANGE CONDITIONS OF PROBATION

I, SARAH WAKEMAN, M.D., hereby state the following to the best of my knowledge, information and belief:

1. I am Medical Director for the Massachusetts General Hospital Substance Use Disorder Initiative.

2. In addition to treating patients as an Addiction Medicine Physician in the Adult Medicine Department of the MGH Charlestown HealthCare Center, I work on designing systems of care for our patients.

3. I am the author of many peer-reviewed articles on substance use disorders and incarceration.

4. I am a member of Governor Baker's opioid task force, a panel of experts that proposed dozens of ideas to the Governor to manage the opioid crisis.

5. I am Chair of the Policy Committee, Secretary, and Board member of the American Society of Addiction Medicine, Massachusetts Chapter. I am chair of the Prisoner Working Group for the national American Society of Addiction Medicine.

6. My curriculum vitae is attached to this affidavit.

7. Attorney Lisa Newman-Polk has consulted my expert opinion on substance use disorder and asked me to provide this affidavit for purposes of explaining the science of addiction and evidence-based treatments for substance use disorders.

DEFINITION OF SUBSTANCE USE DISORDER/ADDICTION

8. "Substance use disorder"—also known as "addiction" (these terms are used interchangeably in this affidavit)—is a common, complex, consistent and predictable, all-consuming, developmental and chronic brain disease expressed as compulsive behavior through continued use of a substance despite negative consequences.

9. The Diagnostic Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5")—the publication by the American Psychiatric Association that describes standard criteria for the classification of mental disorders—defines substance use disorders as a "cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." P. 483.

10. In the DSM-5, substance use disorders are separated by classes of drugs, including but not limited to opioids, cocaine, alcohol, and cannabis. The addictive use of these substances is defined in the DSM-5 as Opioid Use Disorder, Stimulant Use Disorder (e.g. cocaine), Alcohol Use Disorder and Cannabis Use Disorder.

11. Opioid use disorder commonly involves prescription pain relievers (e.g. oxycodone or percocet) and/or heroin. [Opioids can be naturally occurring (morphine, codeine), semi-synthetic (heroin, hydromorphone, oxymorphone, oxycodone), and synthetic (fentanyl).]

12. To be diagnosed with a substance use disorder (e.g. opioid use disorder), an individual must experience two of the following eleven criteria. The total number of the below criteria are added up to determine whether the substance use disorder is described as mild, moderate or severe subtype.

    a. Substance taken in larger amounts over a longer period than was intended.
    b. Persistent desire or unsuccessful efforts to cut down or control opioid use
    c. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
    d. Craving, or a strong desire or urge to use the substance.
    e. Recurrent use resulting in a failure to fulfill major role obligations at work, school or home.
    f. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
    g. Important social, occupational, or recreational activities are given up or reduced because of use.
    h. Recurrent use in situations in which it is physically hazardous.
    i. Continued use despite knowledge of having a persistent tor recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
    j. Tolerance.
    k. Withdrawal.

13. A primary characteristic of substance use disorder is compulsive use of a substance despite self-destructive consequences, including failure to meet work, family and social responsibilities.

14. The person suffering from a substance use disorder compulsively seeks one or more substances and is unable to exert control over the impulse to use despite negative consequences—such as criminal consequences—including incarceration.

15. For many people, addiction is a chronic disease, meaning that people are not "cured" but rather treatment allows an individual to manage the illness and minimize relapses.

16. Addiction is 40-60% genetic, meaning that just like heart disease or diabetes, about half of an individual's vulnerability to develop addiction is based on a person's genetics at birth.

17. Substance use disorder is a disease in and of itself. While other psychiatric disorders often co-occur with addiction, addiction is not a manifestation of another mental illness.

18. Not all people who use substances become addicted and therefore meet diagnostic criteria for a substance use disorder.

19. As with other chronic diseases where not everyone is equally at risk, not all people who use drugs become addicted.

20. People become addicted to substances at the following rates: tobacco 32%; heroin 23%; cocaine 17%; alcohol 15%; sedatives 9%; cannabis 9%.

CAUSES

21. The causes of addiction are complex, multi-dimensional, and specific to the individual.

22. Onset of addiction depends on many intrinsic and extrinsic factors.

23. To develop a substance use disorder there must be a period of regular substance use; however, regular use of a substance alone is not sufficient to induce addiction. Like other chronic diseases, a substance use disorder develops gradually.

24. A combination of early substance use, family history, trauma, exposure to high-risk environments, and certain mental illnesses can lead to substance use disorders in some people.

25. Physical and/or sexual abuse, witnessing violence, severe stress, and/or peers and/or family members who use substances are significant risk factors for developing addiction.

26. The influence of environmental factors in the disease of addiction is similar to other diseases. For example, heart disease is highly influenced by a sedentary lifestyle,

obesity, and stress. Similarly, diabetes is heavily influenced by genetics and lifestyle factors, such as diet, stress and lack of exercise.

27. As noted above, addiction has a genetic component; 40-60% of an individual's vulnerability to develop a substance use disorder is based on genetics.

28. Although substance use disorder requires the initial choice to ingest a substance, in many medical conditions, voluntary choice initiates the sickness, especially when combined with certain genetic and environmental factors. For example, a sedentary lifestyle and an unhealthy diet are contributory factors to many illnesses, including heart disease, diabetes, and depression.

BRAIN DISEASE

29. Neuroscience research shows that addiction is a brain disease.

30. Over the past few decades there has been extraordinary growth in understanding the science of addiction and its impact on the brain.

31. Studies show that in someone with a substance use disorder, the structure and function of the brain is altered—even after the individual ceases substance use.

32. Repeated substance use induces a series of neuroadaptations in various neuronal circuits in the brain that are involved in motivation, memory, behavior control and disinhibition.

33. For the person suffering from a substance use disorder, fundamental motivational and self-control systems are damaged in the brain and cannot function properly.

34. These alterations to the brain explain why people suffering from a substance use disorder remain at risk for relapse even after long periods of abstinence.

35. ATTACHMENT 1 shows brain imaging and the similarities between substance use disorder and chronic disease. The left side of the page shows the impact of a heart attack on the heart muscle. The healthy heart has an even metabolism whereas the diseased heart has a large scar where there is no metabolism. Similarly, on the right side of the page, when comparing a healthy brain to the brain of a person with a substance use disorder, brain imaging shows decreased metabolism in the frontal cortex, which is the section of the brain associated with judgment and decision-making.

36. Another comparable medical condition is a person who has had a stroke, where part of the brain is damaged and no matter how much the person wants to use that part of the brain to speak or walk, the person is unable. With addiction, the section of the brain that allows a person to make rational decisions—including weighing risks, benefits and consequences—is similarly damaged and malfunctioning

37. ATTACHMENT 2 shows brain imaging of healthy brains versus those of individuals addicted to cocaine, methamphetamine, alcohol, and heroin. The images show that Dopamine D2 receptors are lower in people suffering from addiction. The development of addiction is linked closely to the release of dopamine—which is one of the major feel-good hormones in our brain. Dopamine is released naturally in response to things we are meant to pay attention to, such as food or sex, which are both necessary for the survival of the species. Drugs that are addictive cause much higher levels of dopamine to be released and the quicker the surge of dopamine, the more pleasurable it feels and the more we pay attention to whatever it is that causes the release. In the case of heroin, the brain learns to associate that feel-good feeling with not just the drug but anything associated with it. This is why a person with a substance use disorder may say that he starts feeling good when seeing something associated with drug use before even using the substance. It is also why seeing something associated with drug use, like a syringe, could trigger a person with addiction to want to use. There are variations between people in how many dopamine receptors they have and how much dopamine is released in response to drugs. This has been associated with whether someone in a research study without addiction reports a drug as pleasurable. It is likely that these baseline differences play a role in why one person who takes an opioid describes feeling instantly good and someone else simply reports feeling sleepy and nauseous. Lastly with repeated use there are changes to the brain—and to dopamine release in particular—that mean normally rewarding things like food or sex or human contact no longer are experienced as pleasurable or rewarding in contrast to the much higher levels of dopamine released by the drug. Over time drug use causes a decrease in dopamine receptors as you see in Attachment 2. This means that an increased amount of drug is required for the same effect, leading people to use substances to feel normal rather than to feel good.

38. Unlike heart disease or a stroke, the impact of addiction on the brain can be reversed. See ATTACHMENT 3, a study looking at the brains of methamphetamine users. The left image shows the rainbow-colored healthy brain of a person with no drug use. The middle image shows the less colorful brain of a chronic methamphetamine user. The right image shows that with treatment and resulting sobriety, the brain returned to normal. Importantly, in this study, it took 14 months for the brain to return to normal functioning.

CHRONIC MEDICAL CONDITION

39. Substance use disorder is a chronic medical condition, with treatment outcomes and relapse rates similar to, for example, heart disease, diabetes, and asthma.

40. Substance use disorder also has similarities to other behavioral psychiatric disorders in the DSM-5 such as eating disorders and obsessive compulsive disorders in that all of these disorders are defined by continued engagement in compulsive behaviors that lead to negative outcomes.

41. As with many other chronic medical conditions, substance use disorder is a treatable condition associated with physiologic changes, relapse, inconsistent engagement with treatment, and need for ongoing care.

42. In addition to the similarities in the pathophysiology, efficacy of treatment for substance use disorders mirrors that of other chronic diseases. Just as blood pressure is well-controlled while a patient is on a medication like Lisinopril and/or engages in lifestyle changes, and then may relapse when treatment is stopped, substance use disorder may be controlled while patients are in treatment and on effective medications and relapse in disease severity can occur when treatment is stopped.

43. Follow-up studies show that approximately 40-60% of patients with addiction maintain abstinence after one year of treatment and 40-60% will experience a relapse, which simply means they need to resume treatment or change the treatment plan. This is similar to diabetes, hypertension, and asthma where 40-60% of patients will have a relapse in any given year and need a change to their medical regimen.

44. Recovery from addiction is a long-term process like any other chronic disease where periods of remission may be interrupted by periods of active illness.

45. As with other chronic diseases, addiction treatment generally requires ongoing evaluation and modifications.

46. A study of 2012 and 2013 showed that 40.3 million Americans (15.9%) suffer from drug, alcohol and/or tobacco addictions. By comparison, 27 million Americans suffer from heart conditions, 25.8 million suffer from diabetes, and 19.4 million suffer from cancer. See Center for Behavioral Health Statistics and Quality. (2015). HHS Publication No. SMA 15-4927, NSDUH Series H-50. Retrieved from http://www.samhsa.gov/data/.

47. Despite the fact that twice as many people suffer from addiction as cancer, the United States spends less than half the amount of money on addiction treatment each year than cancer. In 2010, the United States spent $28 billion to treat addiction (40.3 million people) and $86.6 billion to treat cancer (19.4 million people). See Addiction Medicine: Closing the Gap between Science and Practice www.casacolumbia.org.

STANDARD OF CARE

48. Substance use disorder is a treatable medical condition. Research indicates that treatment can benefit even the patient with a severe substance use disorder.

49. More often than not people suffering from addiction want to stop their compulsive use and have sincere intentions to do so; however, for most individuals, recovery from addiction requires treatment and ongoing, intensive support.

50. No single treatment is effective for all individuals. A comprehensive assessment is necessary, as is integrated treatment with a range of treatment options to address myriad

needs including associated medical, social, vocational, and legal issues, and oftentimes trauma and co-occurring disorders such as mood disorders, anxiety disorders and cognitive issues.

51. Treatment is most effective when it is individualized to the patient, supported by social networks, and driven by the patient's needs and preferences.

52. Each person's addiction severity and level of functioning determines the best intensity of clinical services.

53. Medications for Addiction Treatment (MAT) such as methadone, buprenorphine, and naltrexone are evidence-based treatments for opioid use disorder and help patients achieve disease remission.

54. Opioid agonist medications (e.g. methadone and buprenorphine) are not "replacing one addiction for another." Treating an opioid use disorder with an opioid agonist is similar to treating diabetes with insulin. Where some people with diabetes can recover from the disease with lifestyle changes (food and diet), others will require insulin long-term to achieve remission.

55. Three primary evidence-based psychotherapies to treat addiction are motivational interviewing, cognitive behavioral therapy (CBT), and contingency management. These treatment modalities are positive-oriented and non-judgmental.

56. Research shows that ordering, commanding, moralizing, shaming and/or threatening a person suffering from addiction to achieve sobriety is ineffective and counterproductive. In response to this type of treatment, people suffering from addiction oftentimes become angry, oppositional, helpless, ashamed, defensive, disengaged, avoidant and, as a result, oftentimes use more substances.

57. Evidence-based best practices for addiction are person-centered, rooted in hope and respect for the individual.

58. Despite tremendous strides made in understanding the science of addiction, there remains a significant gap between evidence-based treatment practices and actual treatment practice due to society's continued perception that addiction is a social or moral problem rather than a chronic medical condition. For example, for every dollar spent on addiction, 95.6 cents pays for consequences and only 1.9 cents pays for prevention and treatment. (See Addiction Medicine: Closing the Gap between Science and Practice www.casacolumbia.org.)

RELAPSE/ONGOING SUBSTANCE USE

59. Relapse is a common occurrence even when a person with a substance use disorder is in treatment.

60. Most individuals with substance use disorder will recover. For example, in a 42-month long study of people with addiction to prescription opioids who were treated with buprenorphine found that at 42 months, 92% of subjects no longer met criteria for opioid use disorder (Weiss RD, et al. Drug Alcohol Depend. 2015.) However, relapse is a part of the process with the average adult experiencing 5-7 relapses before experiencing stable sobriety. Early relapses in treatment do not indicate that individuals are unlikely to ultimately achieve sustained remission.

61. Like hypertension, the chronic nature of addiction makes relapse likely. Addiction relapse should not be viewed as treatment failure. 30-60% of patients with insulin-dependent diabetes and about 50-80% of patients with hypertension and asthma experience a reoccurrence of their symptoms each year and require at least re-stabilization of their medication and/or additional medical interventions to re-establish symptom remission.

62. Relapse and ongoing substance use is a symptom of the disorder.

63. Relapse is an indication that treatment may need to be altered or enhanced. Successful treatment for addiction, like other chronic diseases, requires ongoing evaluation and modification when necessary.

CRIMINAL SANCTIONS

64. Ordering a person with a substance use disorder to be substance-free as a condition of probation is the equivalent of ordering the person to be in remission for his or her addiction in order to be in compliance with probation and face criminal consequences for not achieving disease remission.

65. Court-ordering a person suffering from addiction to stop using substances—with the inherent threat of punishment for non-compliance—does not address the brain disease of addiction.

66. Substance use disorder usually worsens in response to punishment and is most likely to achieve remission with compassionate, integrated, patient-centered, and consistent treatment.

67. The threat of criminal consequences for substance use can have the effect of encouraging a person with addiction to lie about relapse and/or disappear ("go on the run") rather than authentically engage in treatment. As a result, imposing punitive sanctions for substance use is clinically contraindicated because when a patient fears punishment in response to relapse or ongoing substance use, it is very difficult for treatment providers to engage the patient in productive treatment. A patient must be able to discuss disease relapse without

fear of punishment in order for providers to properly treat the medical condition of addiction.

68. Moreover, treating the symptoms of addiction (i.e. substance use) as criminal perpetuates stigma. This is highly problematic because stigma is the primary reason people who know they need treatment do not access treatment. By imposing criminal sanctions (e.g. incarceration) on a substance-addicted person for use, stigma is perpetuated, creating a barrier to treatment.

69. To order a person with a substance use disorder not to use drugs (i.e. not relapse) while on probation is like ordering a person with diabetes to have no episodes of high blood sugar while on probation.

Signed under the pains and penalties of perjury this 21 day of November 2016.

Sarah Wakeman, MD
Medical Director, Substance Use Disorder Initiative
Massachusetts General Hospital

Psychiatric Evaluation

Name of person examined: Julie Eldred

Date of Birth: 11.30.1987

Defense Attorney: Lisa Newman-Polk, Esq.

Docket Number: 1647-CR-0901

Court: Concord District Court

Date of Report: 11/11/2016

Identifying Information: Julie Eldred is a 28-year-old, single woman who was at the time of my interview, 10/17/16, in substance use disorder treatment at Glennis Sheehan House in Tewksbury, Massachusetts. She was court-mandated to the Sheehan House on September 12, 2016 after being held in jail for 10 days on a probation detainer following a positive drug test for Fentanyl while on probation.

Reason for Referral: Ms. Eldred has endured a difficult childhood marked by long-standing issues with Attention Deficit Disorder, Anxiety, and Substance Use Disorder. Beginning at age 7, Ms. Eldred has been under steady psychiatric care to provide support for chronic difficulty with short attention span, poor social skills, and inability to regulate intense negative mood resulting in temper flares compounded by significant levels of anxiety and depression. Medication has been only moderately helpful. By age 14, she had initiated alcohol use and by age 15, had begun experimenting with illicit substances. Most recently Ms. Eldred meets criteria for Opioid Use Disorder, severe. She is referred for assessment of these issues and recommendations for treatment.

Warning on Limits of Confidentiality: Limits of confidentiality were explained and Ms. Eldred indicated that she understood these limits and freely participated in this interview.

Sources of Information: I relied on the following sources of information in conducting this evaluation of Ms. Eldred:

1. Interview with Ms. Eldred on 10.17.16 for a total of 2 hours utilizing a standardized assessment tool, The Global Assessment of Individual Needs, a recognized standard for mental health and substance use assessment.
2. Consultation with her attorney, Lisa Newman-Polk, Esq.
3. Meeting with Ms. Eldred's parents for approximately 1 hour to review her developmental history on 10/17/16.

4. Telephonic consultation with Ms. Eldred's therapist, Marie Harberger, RN, Psychiatric Nurse.

Review of the following documents:

1. AdCare Hospital Outpatient Services Discharge Summary, dated 6/14/12;
2. Community Healthlink Passages Program, Discharge summary, dated 9/23/13;
3. Emerson Hospital Addiction Recovery Program, confirmation of enrollment, dated 9/2/16;
4. Acton-Boxborough Eligibility Determination for 504 accommodations, dated 5/29/02, 8/30/04, and 9/26/05;
5. Progress Note, Ross K. Peterson, MD, Ms. Eldred's childhood psychopharmacologist, dated 7/21/11
6. Written parental observations of medication response and behavior covering 1995 through 2010;
7. Commonwealth Notice of Probation Violation and Hearing
8. The Patient Health Questionnaire (PHQ-9) for depression screening
9. Mood Disorder Questionnaire for mania screening
10. Generalized Anxiety Disorder scale (GAD-7) for anxiety screening
11. PTSD Checklist-Civilian version for trauma screening

The historical information provided here was obtained from Ms. Eldred, available records, and collateral contacts.

Family and Developmental History

Ms. Eldred was adopted at 10 days old into a family with one son, 4 years older, also adopted. She was raised in Acton, Massachusetts by her mother, a retired medical social worker, who has since owned a pet-walking business, and her father, a retired researcher. Ms. Eldred's parents enjoyed a stable marriage and have lived in the same community for all of her life. From her earliest days with the family, she was described as restless, hard to soothe, and easily agitated. As a toddler, parents noted that she was overly active and had difficulty focusing adequately to master age appropriate skills. She had difficulty in interpersonal situations, tending towards shyness though at times was able to function adequately in social settings. Her behaviors were difficult to manage as she couldn't accept rules, tended to be very persistent and was easily discouraged. Parents noted that she was uncomfortable being touched and usual comfort strategies were not successful. By age 7, parents initiated psychiatric care and she began long course of medication treatment, detailed elsewhere in this report.

By all reports, Ms. Eldred had similar difficulties throughout her school years. Although apparently bright and capable with particular artistic and athletic talent, she had academic difficulties and came to the attention of the Special Education department. She was tested a number of times during her school years, and was generally deemed on the borderline for

needing Special Education services. She received educational support and remained mainstreamed in the classroom. She continued to have difficulties in high school and became more anxious and depressed. Inattention and focusing issues continued to affect her academic achievement. She also continued to have issues accepting limits and had difficulty working effectively with authority figures. She notes that at this point she became aware that she felt she was different than others, and that she always "felt something was off, something was wrong" with her. Her friendships and interests shifted away from focused activities such as sports to activities with friends that her parents describe as "negative." Parents note that effective discipline was very difficult with Ms. Eldred and they found it hard to be "black and white" with her, tended to work with her to build some collaboration so that she could comply with rules. Socially she felt rejected by her peers but was able to establish friendships with a small number of others who were similarly challenged. She was able to graduate with her class in 2006.

Psychiatric History

Beginning very early in life Ms. Eldred began to display significant difficulty with heightened arousal, restlessness, high activity levels, and general issues with frustration tolerance. She was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and initiated on medications at age 7. Records from both parents and her psychiatrist, Dr. Ross Peterson, indicate that she had only a moderate response to medication despite trials on a variety of medications, singly and in combination. At her best, parents report that her attention was somewhat more focused and she was able to function adequately in school, but she was never a particularly successful student. She had limited social skills, poor frustration tolerance, often presented with negative mood and rapidly developed low self-esteem. She was slow to develop an age appropriate internal sense of herself as competent and able to cope with life's stresses and difficulties, leaving her overwhelmed without good coping tools. Ms. Eldred reports a history very consistent with what would be expected for children with serious ADHD for whom medication is only partially effective. These symptoms persisted throughout her elementary and high school years, slowing her maturation towards normal age milestones. Ms. Eldred stopped using any medication for ADHD upon graduation from high school since these medications had not proven to be very effective.

At age 14, Ms. Eldred discovered that substance use helped reduce her negative sense of self, albeit only intermittently. She reported for the first time feeling a sense of internal calm and increased social stability as she made connections with others who used substances. Notably, Ms. Eldred's parents reported that there was information from the adoption agency that indicated her birth mother suffered with Substance Use Disorder, creating a significant genetic risk that Ms. Eldred would also suffer with Substance Use Disorder; those who are genetically at risk often report reduced negative emotion and improved quality of life when they initially discover substances. The risk for subsequently developing Substance Use Disorder is very high for those with genetic risk factors.

Ms. Eldred initiated substance use by drinking alcohol with new friends in an effort to medicate the chronic stress she felt due to academic and social issues; she found that alcohol was very helpful in alleviating her sense that "something was wrong" with her. This feeling was even more effectively alleviated when she was introduced to marijuana at age 15, which she described as fitting her like a hand in a glove. This initiated a cascade of illicit substance use over the next several years, including cocaine and painkillers at 15 years old, benzodiazepines (Xanax, Ativan) at 16 years old, hallucinogens and amphetamines at 17 years, and finally concluding with heroin at 23 years old. She ultimately identified opioids, benzodiazepines, and marijuana as her preferred substances. Amounts used and combinations of these substances has varied over time.

Family members noted that during her high school years, Ms. Eldred often seemed depressed and/or anxious and continued to work with psychiatry to find medication that was helpful. In addition, in 2006, at age 18, Ms. Eldred observed her father fall and sustain serious injuries. She was unable to cope with this experience, exhibited significant trauma symptoms, and entered psychotherapy for the first time with her current therapist, Marie Hurburger, RN. Ms. Hurburger notes that Ms. Eldred had much difficulty learning to trust and stabilize in therapy, and that she was inconsistent in therapy over the next 8-9 years. Ms. Eldred has significant difficulty forming positive attachments to others, noted by both her mother and her therapist; she is eventually able to form attachments but these require much longer periods of time than expected. Ms. Harburger noted that Ms. Eldred has much difficulty noticing and regulating her internal emotions and thoughts, tends to act impulsively and without much forethought as is common in young adults with ADHD. She utilized drugs and drug use rituals to help her manage her emotional states, and found effective relief from her negative moods. This resulted in a severe Substance Use Disorder (SUD) by the time she reached her early 20s, with numerous symptoms including craving, continued use despite recurrent negative outcomes, and withdrawal. She also reports significant symptoms of depression and anxiety over much of her lifetime, both in the context of drug use and during periods of abstinence.

Ms. Eldred reports that most recently she was using cannabis daily with last reported use August 2016, and Fentanyl (opioid), used daily, multiple times a day, with last use in late August 2016. Ms. Eldred reports her last use of any illicit substance was 8/31/16. During this most recent relapse, Ms. Eldred acknowledges that she was intoxicated most of the day, every day, and that her intoxication was significant enough that it impaired her ability to work or function effectively. She used in a variety of situations and tended to use in isolation. Ms. Eldred denies recent injection use though reports using needles previously, last time four years ago. She admits to numerous signs of withdrawal, and notes that these have at times prevented her from meeting her commitments.

Ms. Eldred had some difficulty providing a clear, chronological review of her substance use treatment history. She reports attending three detoxification treatment programs, beginning in 2012 following treatment for intoxication in an Emergency Room. She reports being in residential treatment six times for variable lengths of time. She reports that mandated treatment

related to her legal issues (drug court) initiated her into treatment for her Substance Use Disorder, and she credits her parents, Glenice Sheehan House in Tewksbury, and Narcotics Anonymous (NA) with helping her enter into and engage recovery. She describes two episodes of Medications for Addiction Treatment (MAT) and has three previous episodes of outpatient addiction treatment. In 2014, she was able to enter a more stable recovery while in treatment at Glenice Sheehan House, which she completed in December 2014. Ms. Eldred reports that various programs court-ordered prior to Glenice Sheehan House did not work well for her individual needs. As a result, she researched treatment programs and specifically asked the drug court to allow her to attend Glenice Sheehan House, believing she would benefit from the program's animal (horse) therapy. Ms. Eldred sustained her recovery and graduated from the Concord Drug Court in March 2015. During this time she achieved a level of stability, benefitting from the social support provided by mutual aid groups.

Ms. Eldred experienced a relapse with opioids (Fentanyl) in November 2015 due in part to gradually withdrawing from her treatment supports. She continued to use increasing amounts due to the developing tolerance and the rapid half-life of Fentanyl, which causes users to rapidly enter withdrawal states. She required ever increasing amounts of money to obtain enough drugs to avoid acute withdrawal symptoms, and eventually was arrested for larceny in August 2016. Ms. Eldred was placed on probation, and again entered Suboxone treatment but initially had trouble managing her cravings, as is often the case with Fentanyl due to the very short half-life of this particular drug. She applied for additional supports and was accepted into the Addiction Recovery Program at Emerson Hospital, but was incarcerated for violating probation when she tested positive for Fentanyl on 9/02/2016. She has since returned to Glenice Sheehan House where she is reportedly doing well and sustaining her recovery once again. She is no longer using Suboxone or any other opiate substitution therapy. Ms. Eldred reports that she benefits from the structure and skills training she receives while in residential care, particularly the focus on life skills, communication and problem-solving. She notes that she benefits from mutual aid groups where she has a positive social connection, though she does not have a sponsor.

As a part of this evaluation, Ms. Eldred completed a number of mental health screening tools to assess her current symptoms. Screening results indicated that at present she is not experiencing symptoms of depression, anxiety, mania, or trauma. On interview, Ms. Eldred reports that she has experienced symptoms of depression over the last year, worse when she is using substances but present much of the time. Her therapist noted that she has not diagnosed Ms. Eldred with depression or anxiety, but that Ms. Eldred will exhibit these symptoms in response to life stresses and disappointments; symptoms improve when life stress is reduced. Ms. Eldred notes that she feels very supported and positive at present in residential treatment, apparently corroborating her therapist's opinion that these symptoms are typically more related to external pressures than an internal state.

Academic History

As discussed earlier, Ms. Eldred suffers from serious ADHD with symptoms present throughout her school history. She was only moderately responsive to medication, and completed a variety of medication trials throughout her elementary and high school years. She was evaluated for Special Education Services, but was consistently on the borderline for eligibility; she remained mainstreamed and provided support, and was able to function on a low average level. She was able to graduate in 2006 from a local area high school and reports that has been working on an associate degree in liberal arts with an emphasis on animal behavior at a local community college. It is unclear whether she has completed this degree at present. Parents note that she has always had an affinity for working with animals.

Employment History

Ms. Eldred initiated employment outside the home at age 16 when she was able to work successfully in a child care setting for several months. Unfortunately she was terminated related to her marijuana use. This pattern has been repeated numerous times in the ensuing years. She has had a number of jobs, is able to maintain them for a few months, and is then terminated typically for substance use related issues. Her one stable employment has been working in her mother's pet walking business. Mother reports that she was very reliable and works well with the animals; this is also the context in which she was arrested for larceny. She has not applied for other jobs in the last few months while she is in residential treatment, and her parents are her sole financial support at this time.

Social History

Ms. Eldred has experienced a fairly typical course of social issues for children with serious ADHD. She had difficulty fitting in socially when she was younger, tended to become upset easily and was at times rejected by peers. She found substance using peers more accepting, and until she began treatment tended to have friends who used substances similarly. She currently has two good friends, both men, and her parents note that she has often preferred male peers to female. She denies that any of her current friends are active substance users, noting that her primary social contacts come from her mutual aid groups. Parents report that she has formed more positive relationships with other women since she has been in residential treatment. Ms. Eldred acknowledged that her current boyfriend uses alcohol in a limited way and has a medical marijuana card; parents reported that while he has been in their home, he has not used substances inappropriately to their knowledge and they have no concerns about this.

Ms. Eldred typically resides at home with her parents and has not previously lived independently. Her boyfriend has been living with her parents as well, and remains there though Ms. Eldred is in residential treatment. Parents are both very supportive; mother has retired from her pet walking business and father is retired as well. She has little contact with her brother. She has few social supports outside of mutual aid groups and no particular affiliation with any

religious or social institution or activity. She has no particular hobbies or interests other than her interest in animals. She has much difficulty creating and implementing structure in her day to day life.

Collateral Interviews:

Mr. and Mrs. Eldred, Ms. Eldred's parents, were interviewed on 10/17/16 in person at my office. They were very supportive of their daughter and appeared to be forthcoming throughout the interview. They confirmed that her early years were very difficult for everyone due to her developing ADHD symptoms. She had difficulty managing limits and was very hard to soothe owing to the fact that she could not tolerate touch and didn't respond well to verbal soothing. They describe years of trying to anticipate her needs, modifying and managing situations so as to limit the amount of distress she would experience. Their efforts to identify effective treatment, both pharmacological and behavioral, is documented in a log that mother kept over her elementary and high school years. They describe a gradual course of loss of self-esteem, loss of social standing and functionality over the years as Ms. Eldred slipped further behind her age peers in academic and social functioning. They reported that in her mid teens it seemed to them that she had undergone a "total personality change" as many of her symptoms became exaggerated; they were unaware that at the time Ms. Eldred had initiated alcohol and drug use. After high school they have remained very involved in Ms. Eldred's life, expecting her to engage in treatment of her substance use disorder and supporting her financially through the process. They are concerned about her path forward and remain committed to supporting her though they expect that she will enter and sustain recovery.

Mental Status and Current Level of Functioning:

I interviewed Ms. Eldred on 10/17/16 at my office on the campus of Massachusetts General Hospital. Ms. Eldred arrived with her parents and lawyer, dressed casually and appropriately. She appeared to be of normal weight and height, and seemingly was in good health. She was easily engaged in the interview, established good rapport, made good eye contact, and was forthcoming throughout. She appeared to make every effort to respond fully to all questions and her responses were appropriate. She had little difficulty moving from topic to topic, adapting easily to the interview process.

Ms. Eldred reported lifelong issues with attention and information processing evident during the interview, though significant memory issues were not observed. Her behavior during the interview was appropriate with no evidence of agitation or inappropriate activity. Her speech and language were clear, age appropriate, and she was effective in her communications. She appeared to be of average intelligence with somewhat limited insight. Over the course of the interview there was no sign of impairment in the thinking process. She was clear and logical in her responses. She noted symptoms of anxiety and depression in the past, though denied any symptoms at present. She seems to experience these symptoms in relation to stress and

complications from living with ADHD and Substance Use Disorder. She denied any suicidal or homicidal ideation, and noted that she felt well supported by her therapist and parents. She reported the SUD treatment program was very helpful to her and she felt hopeful.

Impressions:

Ms. Eldred has clearly suffered throughout her life with the impact of severe Attention Deficit Disorder, with symptoms onset in very early childhood, complicated by early onset Substance Use Disorder. As is so common with ADHD, the early onset of impaired ability to focus her attention and manage her internal states negatively impacted her developmental trajectory and age appropriate functioning. She was restless and easily agitated, difficult to manage even as a toddler. She lacked persistence, was easily discouraged, and hasty in her decision making. These difficulties followed her into her school years, and were not mitigated with additional cognitive development. Academically she was evaluated for Special Education services, but remained mainstreamed and coped as best she could. Socially she alternated between trying to control the situation or withdrawing from interaction due to her difficulty in tracking the flow and process of social interaction. She was vulnerable socially and often ostracized as a child and teen. Efforts to find effective treatment were only moderately successful and she endured numerous medication trials, both single medications and combinations of medications. Her parents were attentive and observant of her needs but she continued to struggle with her disabling ADHD throughout her elementary and middle school years. She reports feeling different than other children, and feared that there was something wrong with her. Her academic progress was delayed and her social/problem solving skills were also impeded. She began to see herself as less capable than others, and she did not develop a strong sense of herself as competent or effective in taking on the challenges inherent in growing up. She did not master skills in regulating emotions or managing impulses and she lacked the confidence to tackle the challenges required for age appropriate developmental maturity.

Upon entering high school, she was exposed to alcohol and illicit drug use, as well as cigarettes. As happens so frequently for youth with ADHD, she found that using substances helped her feel more normal and more effective with her peers. She states that she began using substances to help medicate the anxiety and depression she experienced in relation to her limited academic and social success. After her initiation into use of substances at age 14, she continued to experiment with a broad range of substances over the next 9 years. By age 23, she had settled on opioids, particularly Fentanyl, in combination with marijuana as her preferred illicit combination. During these years, a normal developmental trajectory was further impacted. Her moods were more variable and normal developmental milestones were either missed or only partially met. For example, she has been unable to complete an education, establish stable employment, or move out of parents' home. She has been largely impacted by the challenges inherent in long term drug use, e.g., spending much time focused on drug use, finances being dedicated to drugs, lost employment due to drug use, relationships structured around drug use, and legal issues related to drug use.

Beginning in 2013, she started the process of recovery and since this time has had periods of remission and periods of relapse of her Substance Use Disorder. She was able to benefit from treatment, despite attending a number of different treatment programs with varying success. Since Substance Use Disorder normally has a chronic, relapsing course, efforts at recovery are typically characterized by a series of abstinent periods followed by periods of active use with return to periods of recovery. The expected course is that the length of each relapse is reduced over time and the length of time between relapses begins to lengthen, and this cycle repeats several times over a period up to 10 years. Ms. Eldred exhibits a fairly typical recovery process where early recovery was complicated by cycles of recovery followed by relapse followed by renewed efforts at recovery. It is clear that she has made good use of her treatment opportunities, has learned from her treatment failures and has at times been able to sustain recovery for several months at a time. The most recent relapse in November 2015, followed nearly one year of sustained recovery using a number of elements of an effective recovery plan, including therapy, work, and peer recovery supports, e.g., NA. She attributes the relapse to avoiding key elements of her recovery plan, believing that she was able to sustain her recovery without as much support. She is now more aware that the chronic nature of substance use disorders requires that she engage in more long-term, intensive support to sustain recovery.

Ms. Eldred also reports occasional bouts of anxiety and/or depression that are episodic and more related to environmental stresses than primary mental health disorders. She does, however, suffer long-term effects from the impact of ADHD on normal adult development. She is delayed in her development of adequate emotional coping and problem solving skills, resulting in greater vulnerability to return to use of illicit substances to provide rapid relief from this long- term work. She is able to continue to develop these skills as she works through the normal developmental challenges of maturing into an adult, but will need ongoing support to continue make these efforts. The work of mastering these developmental challenges can only be done gradually in experience based settings with oversight and guidance from therapeutic professionals. She must face choices, resolve uncertainties, test hypotheses, assess outcomes, and try again, because this is the only way to accomplish the task of maturation. She must have the opportunity to cope with urges, impulses and lapses (relapses) in an environment where she feels safe enough to acknowledge her difficulties and concerns if she is to overcome the impact of substance use and ADHD on her development. She will need the help and constant support of her trusted team. As a result, time spent incarcerated will only further delay the development of skills necessary to manage her ADHD and her emotional life, putting her further at risk for relapse. Ms. Eldred's combined psychiatric disorders require that she remain in long- term treatment with gradual step down, and sustain her recovery plan by engaging consistently with her recovery resources. She needs the opportunity to begin to adapt to normal developmental challenges of community life in order to build stronger internal processes if she is going to be able to manage her future challenges successfully.

Ms. Eldred reflected on the impact of the time she has spent incarcerated as she works to treat her chronic psychiatric conditions. She notes that she has found the experience overall to be highly stressful with significantly negative impact on her recovery efforts. Her awareness of the consequences of relapse while on probation has the inverse effect of raising her stress levels significantly, putting more pressure on her limited coping ability and increasing her risk for relapse. She recalls the experience of incarceration as dehumanizing and shaming, and ruminating about these experiences exacerbates her anxiety and depression to the degree that she experiences an increased risk for use. Fear of being incarcerated causes her to withdraw and avoid reaching out for help, putting Ms. Eldred in a difficult double bind.

Recommendations:

1) Ms. Eldred should complete her current residential placement in halfway house (Glenice Sheehan). She should work with her current care team, including her therapist, to identify appropriate step down services. Due to the chronic, relapsing nature of substance use disorders, Ms. Eldred would benefit from a discharge plan that gives her continued access to therapeutic services in which she can process and learn from any additional relapse/recovery cycles she may experience. The treatment plan should include gradual reductions in service intensity over at least the next two years based on her levels of functioning in the programs. She will likely need some assistance from her therapist or other case manager to assure a smooth transition through the treatment system. Critically, Ms. Eldred should feel that she is a collaborator with her providers on treatment decisions.

2) Ms. Eldred would likely benefit from ongoing involvement with others in recovery. Peer based services, such as AA/NA, have demonstrated significant positive impact on long-term outcomes and stability of recovery. She would benefit from identifying a home group, a sponsor, and making a commitment to working through the social support offered by these groups.

3) Ms. Eldred should remain in her current individual therapy as a way to process all of the other treatment and consolidate her gains in the focused substance use therapies. Ms. Eldred and her therapist should consider the utility of participation in group therapy as a method of improving her social skills and assisting her to meet developmental challenges.

4) Careful consideration must be given to the psychosocial challenges Ms. Eldred faces if she is to achieve a stable long-term recovery. She and her treatment team must address the issue of finding and sustaining employment, possibly finishing her certificate or degree at community college, and finding a way to sustain a move out of her parents' home. Ms. Eldred likely has additional desires and wishes to improve the quality of her life which should be incorporated into treatment.

5) Additional incarcerations are unlikely to assist Ms. Eldred in achieving more stable sobriety. The threat of jail in and of itself puts Ms. Eldred's recovery at risk. Fear that incarceration or other criminal sanctions will result from the expected issues with relapse and re-entry into

recovery impedes Ms. Eldred's ability to honestly address the symptoms of her disease (relapse) as they occur. The shame, fear, and anxiety associated with the threat of return to prison are likely to interfere in the progress of treatment for this chronic disease. The escalating anxiety reported by Ms. Eldred associated with the probation condition increases the risk of relapse rather than reducing it. The threat of reincarceration is clinically contraindicated because of the effect it has on Ms. Eldred's mental health and course of treatment.

11/21/16
Date

Martha J. Kane, PhD
Martha Kane, Ph.D.
Clinical Director, Center for Addiction Medicine
Clinical Director, Substance Use Disorders Initiative
Clinical Director of Ambulatory Psychiatry
Massachusetts General Hospital

CERTIFICATE OF SERVICE

I, Benjamin H. Keehn, certify that I served the foregoing Application for Direct Appellate Review, and Memorandum and Addendum in support thereof, by causing copies to be mailed, first-class and postage prepaid, to:

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